PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495227	B. WING _			C 09/29/2016
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, Z 7300 FOREST AVE RICHMOND, VA 23226	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIA	
	An unannounced Me survey was conducted Complaints were invectorections are requifollowing 42 CFR Part Care requirements. Survey/report will follow the census in this 22 178 at the time of the consisted of 24 curres (Residents #1 through reviews (edicare/Medicaid standard and 9/27/16 through 9/29/16. Pestigated during the survey. Fired for compliance with the rt 483 Federal Long Term The Life Safety Code low. 25 certified bed facility was a survey. The survey sample lent resident reviews (h #24) and 11 closed record (h #25 through #35). ES ROOM, ETC) It is interested to the resident; lent's physician; and if ident's legal representative by member when there is an expression of the resident's physician cant change in the resident the physician change in the physician change in the physician change in the ph	F	CROSS-REFERENCED	TO THE APPROPRIA	
	the resident from the §483.12(a). The facility must also	sion to transfer or discharge facility as specified in promptly notify the resident sident's legal representative				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE

10/21/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		C 09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		7300 FOREST AVE		
WEOTI OI	T REHADIEHAHON AN	B NOROMO GENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	BE COMPLETION	N
F 157	Continued From page		F 1	57		
	change in room or roo specified in §483.15(resident rights under regulations as specifi- this section. The facility must reco the address and phor	Federal or State law or ed in paragraph (b)(1) of ordered and periodically update ne number of the resident's				
	This REQUIREMENT by: Based on staff interv and review of facility determined that the faphysician when medicadministered as orde for one of 35 resident Resident's #15. The facility staff failed Resident #15's physiciatab (used to treat con administer to Resider in July and August of The findings include: Resident #15 was ad	mitted to the facility on		1. Corrective Action The physician and responsible party notified of resident # 15's random re of Senexon S Tab 8.6 - 50 MG' 2.Other Potential Residents An audit of the MARS (Medication Administration Records) for all residents been completed and no other residents were affected. 3.System Changes Unit Managers and Licensed Nurse were re-educated on appropriate documentation on back of MARS (Medication Administration Records) medication that is refused and the nefor physician notification regarding the refusal.	ents for a	
	limited to: high blood diabetes, depression, of falls. The most recent MDS	constipation, and a history		refusal. A 100% audit of all MARS (Medication Administration Records) will be completed with documentation and notification. areas of non-compliance will be	leted ance	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	1	X3) DATE SURVEY COMPLETED	
		495227	B. WING_			C 09/29/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226	I)E	09/29/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIAT		
F 157	coded the resident at to make cognitive da was coded as requirione staff member for living except, eating, independent after se provided. The physician orders documented, "Senex constipation (1)) (tab 1 tablet by mouth twi Management." The July 2016 MAR record) documented, MG; 1 tablet by mouth management." The Mollowing dates, a cirnurse for the 5:00 p. 7/5/16 through 7/8/16 7/15/16 through 7/8/16 7/15/16 through 7/18 7/29/16. This was 17 administration/docum of the MAR did not dadministering the member of the 5:00 MG; 1 tablet by mouth administering the member of the MAR did not dadministering the member of the 5:00 MG; 1 tablet by mouth administering the member of the Side MAR did not dadministration/docum of the MAR did not di	reference date of 8/25/16, s being moderately impaired ily decisions. Resident #15 ng extensive assistance of all of her activities of daily in which she was t up assistance was dated, 6/18/16, son - S tab (used to treat let) 8.6 - 50 MG (milligrams);	F1	immediately corrected and st responsible will be counseled. 4. Monitoring Results of the audits will be fithe QAPI Committee for furth and recommendations.	d. orwarded to	0	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495227	B. WING		C 09/29/2016
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	03/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 157	"Made aware by 7-cresident was constituted aware - VO (verbal (immediately)." Further record reveled no function of the sabove regard administered or not medication was not the comprehensive revised on 9/1/16, of Elimination Alteration of exercise, constip "Interventions" documedications per phy An interview was concept the MAR indicated, wasn't given. The reback of the MAR with the doctor and the result of the made on the back of the Mark of the	atted, 7/19/16, documented, 8 (7:00 a.m. to 3:00 p.m.) shift pated and (Name of doctor) order) enema STAT ther review of the clinical arther documentation on the ing the medication not being ification to the physician then administered. The care plan dated, 6/20/16 and documented, "Focus: Bowel on; Constipation related to lack ation, impaired mobility." The amented in part, "Administer ysician order." The onducted with LPN (licensed on 9/28/16 at 1:23 p.m. When around a nurse's initials on LPN #7 stated, "It means it nurse should document on the my it wasn't given and notify	F 15		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		C 09/29/2016
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 157	After administering a record: drug given, d administration, signin patients medication rewithholding of a drug refused, withheld, or prescriber must be not Administrative staff m administrator, ASM # administrator of clinic assistant administrator	nentals of Nursing- nd Wilkins 2007 page 165: tablet or capsule, be sure to ose given, date and time of g out the drug on the ecordany omission or for any reason. If a drug is omitted for any reason, the otified " tember (ASM) #1, the 4, the assistant al services, ASM #4, the or, and ASM #6, the medical aware of the above concern	F 15		
F 252 SS=D	No further information (1) https://dailymed.nlm.im?setid=bb2064aa-b2df SAFE/CLEAN/COMFENVIRONMENT CFR(s): 483.15(h)(1) The facility must provomfortable and hom the resident to use hit to the extent possible This REQUIREMENT by: Based on observation	n was provided prior to exit. nih.gov/dailymed/drugInfo.cf 820-4e07-962a-a50614594 ORTABLE/HOMELIKE ide a safe, clean, elike environment, allowing s or her personal belongings	F 25	1.Corrective Action The wheelchair cushion for resident #	10/21/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		495227	B. WING _				C /29/2016
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	20/2010
				7	7300 FOREST AVE		
WESTPOR	RT REHABILITATION AN	ID NURSING CENTER		ı	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 252	Continued From pag	ne 5	F 2	252			
	was determined that	the facility staff failed to			was replaced on 9/29/16		
	provide a clean, com	fortable environment for one					
	#12.	e survey sample, Resident			2.Other Potential Residents Wheelchair cushions were checked for other residents that have them in place.		
		d to provide a wheelchair and exposed foam rubber			and no other residents were affected.		
	for Resident #12.				3.System Changes		
					Staff were re-educated to observe for		
	The findings include:				wheelchair cushions that need to be		
	Decident #10 was as	dusitional to the famility and			repaired or replaced during their daily		
		dmitted to the facility on ses including, but not limited			interactions with residents. Rounds of all units will be completed		
		e, dementia, and diabetes.			weekly x 3 months to validate that		
		MDS (minimum data set), a			residents have appropriate wheelchair		
		nt with assessment reference			cushion's that are not in need of repair		
		ent #12 was coded as being			replacement Any areas of non-complia		
		impaired for making daily			will be immediately corrected and staff		
	decisions. She was	coded as requiring a			responsible will be counseled.		
	the facility.				4. Monitoring		
	-				Results of the rounds will be forwarded	l to	
		.m. and on 9/29/16 at 9:15			the QAPI Committee for further review		
		vas observed sitting in her			and recommendations.		
		llway outside her room. On					
		cover of the cushion in					
		elchair was observed to be					
	torn, leaving areas o	f exposed foam rubber.					
	A review of the comm	orehensive care plan for					
		3/24/15 and most recently					
		ealed, in part, the following:					
		ing device on bed/chair."					
	On 9/29/16 at 9:50 a	ı.m., CNA (certified nursing					
		bserved to pass by and					
		nt #12 as the resident sat in					
		A #14 was asked if she					
	observed anything o	ut of the ordinary with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		495227	B. WING		09	C 0/ 29/2016
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE 7300 FOREST AVE RICHMOND, VA 23226	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 252	When asked to look wheelchair and acce "Oh, I see it." She so cushions for tears an stated she could see cushion's cover in set this is acceptable for not. When asked if clean, comfortable, I Resident #12, CNA stated: "We can't clean process to be follow in disrepair, she stat (rehabilitation service for her." On 9/29/16 at 9:55 anurse) # 15 was interested in the wound what kind of cushion that is torn a She stated: "This is would call the wound what kind of cushior has the same kind of Con 9/29/16 at 11:25 staff member) #1, the assistant administra ASM #5, the assistat informed of these condurable medical equirequested. A review of the facilie "Disinfection/Steriliz"	#14 stated she did not. more closely at the resident's essories, CNA #14 stated: stated she usually looks at and other abnormalities. She arip in the wheelchair everal places. When asked if a resident, she stated it was the cushion promoted a shomelike environment for #14 stated: "No." CNA #14 ean it." When asked the ed if she observed a cushion red: "I would call rehab es). They will get a new one a.m., LPN (licensed practical erviewed. She stated it was dent to be seated on a and displaying exposed foam. an infection control issue. I do nurse to help determine a is needed. Not everyone of cushion." a.m., ASM (administrative the administrator, ASM #4, the tor for clinical services, and and and instrator, were oncerns. Policies regarding hipment condition were	F	252		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495227	B. WING			C 9/29/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 0	9/29/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 252 F 278 SS=D	ASSESSMENT ACCURACY/COORD CFR(s): 483.20(g) - (The assessment must resident's status. A registered nurse meach assessment witt participation of health A registered nurse massessment is complemental to complemental to the com	n was provided prior to exit. DINATION/CERTIFIED j) st accurately reflect the ust conduct or coordinate th the appropriate n professionals. ust sign and certify that the eted. completes a portion of the in and certify the accuracy of sessment. Medicaid, an individual who y certifies a material and resident assessment is ey penalty of not more than resment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each	F 25	52		10/21/16
	by: Based on staff interv	Γ is not met as evidenced riew and clinical record lined that the facility staff		Corrective Action 1.The MDS (Minimum Data Set)) for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
		495227	B. WING _				C 29/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2010
				7:	300 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	e 8	F 2	278			
		omplete and accurate of 35 residents in the survey 6.			Resident # 4 has been corrected to ref the coding of dialysis.	lect	
	set) assessment with	ission MDS (minimum data a an ARD (assessment 26/16 failed to document ceiving dialysis.			2.Other Potential Residents An audit of the MDS (Minimum Data Set)for all other residents who were receiving dialysis was completed and r other residents were affected.	10	
	The findings include:				3.System Changes The MDS/Care plan Nurses were		
	7/26/16 with diagnos limited to: encephalo convulsions (3), hype Parkinson's disease. Resident # 16's most (minimum data set) a with an assessment in 7/26/16, coded the return brief interview for score of 0 - 15, two brief of daily decision mal coded as requiring extaff member for active Section O: "Special Technology of the staff member for active Section O: "Special	dmitted to the facility on es that included but were not pathy (1), dysphagia (2), ertension (4), kidney failure, (5) and heart disease. It recent comprehensive MDS an admission assessment, reference date (ARD) of esident as scoring a two on mental status (BIMS) of a being impaired of cognition king. Resident # 16 was extensive assistance of one wities of daily living. In Treatments, Procedures and evidence documentation of			re-educated on accurate coding of MD (Minimum Data Set)Assessments for residents receiving dialysis. A 100% audit of the MDS (Minimum Data Set)for all dialysis residents will be completed weekly x 3 months to validate accurate coding of dialysis. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review and recommendations.	ata te of	
	through 9/30/2016 fo "Dialysis Days: Tuesdat (Name of Dialysis The care plan for Res	sident # 16 documented, related to acute renal failure.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		OMPLETED
		495227	B. WING			C 09/29/2016
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	Continued From pa	nge 9	F 27	8		
	conducted with RN coordinator regardi for Resident # 16's MDS (minimum dat ARD (assessment After reviewing the have a care plan for coded in section "Cowhat guidance they RN # 5 stated, "We assessment instrum CMS's (Centers of (resident assessment After reviewing the have a care plan for coded in section "Cowhat guidance they RN # 5 stated, "We assessment instrum CMS's (Centers of (resident assessment assessment instrum CMS's (Centers of (resident assessment	Medicare/Medicaid) RAI ent instrument) Version 3.0 6 documented, "SECTION O: ENTS, PROCEDURES, AND If the items in this section is to treatments, procedures, and resident received during the ods. reatments, Procedures, and retreatments, programs and resident performed residently or after set-up by				
	provided solely in or procedure or diagn medications or ven include routine preprocedures. Item Rationale Health-related Qua	-				
	in Item O0100, Spe	rocedures, and programs listed ecial Treatments, Procedures, have a profound effect on an				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		495227	B. WING _			C 09/29/2016
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	TY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	Continued From page	ge 10	F 2	78		
	individual 's health and quality of life. CMS's RAI Version [O] May 2013 Page O-2 O0100: Special Tree. Programs (cont.) Planning for Care. Reevaluation of sp. procedures the resiperograms that the resiperograms that the resiperograms that the residents who per programs, and/or preducated by the face performance of these any equipment need appropriate use and these tasks. Steps for Assessmental Review the residents who per programs within the Coding Instructions. Check all treatment received or perform admission/entry or in the 14-day look-back blank if the resident reentered the facility items apply in the latter the above. Coding Instructions Check all treatment received or perform the latter apply in the	status, self-image, dignity, 3.0 Manual CH 3: MDS Items 2 atments, Procedures, and ecial treatments and dent received or performed, or esident was involved in during sk period is important to ed appropriateness of the ares, or programs. Form any of the treatments, rocedures below should be sility on the proper se tasks, safety and use of ded, and be monitored for dicontinued ability to perform ent ent's medical record to or not the resident received or e treatments, procedures, or last 14 days. for Column 1 s, procedures, and programs ed by the resident prior to reentry to the facility and within sk period. Leave Column 1 was admitted/entered or y more than 14 days ago. If no ast 14 days, check Z, none of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	· /	TE SURVEY MPLETED
		495227	B. WING		,	C 9/29/2016
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	procedures that the themselves indeper facility staff. Do not provided solely in concedure or diagnormedications or vent include routine preprocedures. O0100J, Dialysis Code peritoneal or rethe nursing home of Record treatments of Continuous Ultrafiltr Arteriovenous Hemoleton Continuous Ambula (CAPD) in this item. transfusions administrative part of the to be coded und (Parenteral/IV), O01001 (transfusion the resident perform On 9/28/16 at approximation (ASM) for clinical services	treatments, programs and resident performed dently or after set-up by code services that were onjunction with a surgical estic procedure, such as IV dators. Surgical procedures and post-operative renal dialysis that occurs at reat another facility in this item. of hemofiltration, Slow ation (SCUF), Continuous offiltration (CAVH), and tory Peritoneal Dialysis IVs, IV medication, and blood stered during dialysis are ne dialysis procedure and are er items K0510A 00H (IV medications), or s). This item may be coded if is his/her own dialysis."	F 27	78		
	References: (1) A term for any di	on was provided prior to exit. ffuse disease of the brain that or structure. This information he website:				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		C 09/29/2016	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 03/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 278	y/encephalopathy.htm (2) A swallowing discomposed obtained from the weak https://www.nlm.nih.gsorders.html. (3) The term "seizure interchangeably with the physical findings occur after an episod activity in the brain. obtained from the weak https://medlineplus.gd. (4) High blood pressure obtained from the weak https://www.nlm.nih.gessure.html. (5) A type of movement information was obtained https://www.nlm.nih.gsease.html. (6) Dialysis treats end removes waste from kidneys can no longer (and other types of diof the kidneys when the information was obtained managed information was obtained wa	gov/disorders/encephalopath n. Inder. This information was bsite: gov/medlineplus/swallowingdi It is often used It convulsion. A seizure is or changes in behavior that the of abnormal electrical This information was bsite: gov/ency/article/003200.htm. Jure. This information was bsite: gov/medlineplus/highbloodpr	F 27	8		
F 279 SS=D		HENSIVE CARE PLANS 83.20(k)(1)	F 27	79	10/21/16	
	A facility must use the	e results of the assessment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 09/29/2016		
NAME OF P	ROVIDER OR SUPPLIER	100221	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	29/2016	
					800 FOREST AVE			
WESTPOR	RT REHABILITATION A	ND NURSING CENTER			ICHMOND, VA 23226			
(X4) ID PREFIX TAG			ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 279	The facility must develop and for each reside objectives and timet medical, nursing, an needs that are ident assessment. The care plan must to be furnished to at highest practicable pysychosocial well-be §483.25; and any see be required under §483.10, including the under §483.10, including the under §483.10 (b)(4) This REQUIREMENT by: Based on staff interreview, it was determined to develop a cone of 35 residents Resident #1. The facility staff failed comprehensive care area of dental care of change in status ME	relop a comprehensive care not that includes measurable ables to meet a resident's d mental and psychosocial iffied in the comprehensive describe the services that are tain or maintain the resident's ohysical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided a exercise of rights under ne right to refuse treatment. T is not met as evidenced wiew and clinical record mined that the facility staff omprehensive care plan for in the survey sample,	F	2279	1. Corrective Action The care plan for Resident #1 was updated to reflect a care plan for the triggered care area of dental care. 2. Other Potential Residents An audit of the Care Plan for residents that triggered for dental care on the CA (Care Area Assessment)was complete and no other residents were affected. 3. System Changes MDS/Care plan nurses were re-educated.	AA ed		
	The findings include Resident #1 was ad	: mitted to the facility on 1/8/16.			on process to ensure that the care plan for residents that trigger in the CAA (C Area Assessment) for dental care has	are		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		0.9	C 9/29/2016	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 279	limited to: mood discomajor depressive discomajor depressive discomajor depressive discomajor depressive discomajor depressive discomande in status ass 9/1/16, coded the resimpaired. Section V (CAA) Summary" do A if Care Area is trigg Care Area, indicate v care plan revision, or plan is necessary to identified in your ass The Care Planning Ecompleted within 7 d (resident assessment CAA(s)). Check coluarea is addressed in documented in the "Care Planning Decicare area of "15. Deciarea would be care governed with a completed with RN (coordinator). RN #5 developed for a care documented to be care of derivating derivation of the coordinator of the coordinators referenced was just missed." R coordinators referenced.	sees included but were not order, muscle weakness and order. ecent MDS, a significant essment with an ARD of sident's cognition as severely "Care Area Assessment cumented, "1. Check column gered. 2. For each triggered whether a new care plan, or continuation of current care address the problem(s) essment in the care area. Secision column must be ays of completing the RAI at instrument) (MDS and amn B if the triggered care the care plan" An "X" was Care Area Triggered" and sion" columns beside the intal Care" indicating the care planned. #1's comprehensive care indicated to reveal ding dental care. #1, an interview was registered nurse) #5 (MDS stated a care plan should be area that triggers and is are planned. RN #5 #1's comprehensive care ent information regarding the stal care. RN #5 stated, "It N #5 stated the MDS ce the CMS (Centers for it Services) RAI (Resident	F 279	care plan that addresses that A 100% audit of all residents the CAA (Care Area Assessm dental care will be completed months to validate presence oplan for dental care. Any areas non-compliance will be immed corrected and staff responsible counseled. 4. Monitoring Results of the audits will be for the QAPI Committee for further and recommendations.	that trigger in ent) for weekly x 3 of the care s of diately e will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING_			C 09/29/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		3372372016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 279	care areas on the MD On 9/29/16 at 11:25 a staff member) #1 (the (the assistant adminis and ASM #5 (the assi made aware of the ab The CMS RAI manua "Coding Instructions for Facility staff are to us mechanism to determine require review and ac triggered care areas a "Care Area Triggered each triggered care a and current standard or expert-endorsed cl resources to conduct care area. Document information regarding Chapter 4 of this man instructions on the CA and documentation. For each triggered ca Planning Decision" is new care plan, care p of the current care pla the issue(s) identified care area. The "Care must be completed w the RAI, as indicated which is the date that decision(s) were com resident's care plan w	s based on the triggered is assessments. I.m., ASM (administrative administrator), ASM #4 strator of clinical services) stant administrator) were love findings. I documented the following: or V0200A, CAAs see the RAI triggering line which care areas additional assessment. The lare checked in Column A in the CAAs section. For trea, use the CAA process of practice, evidence-based linical guidelines and further assessment of the trelevant assessment the resident's status. It was process, care planning, are area, Column B "Care checked to indicate that a clan revision, or continuation and is necessary to address in the assessment of that the Planning Decision" column lithin 7 days of completing by the date in V0200C2, the care planning pleted and that the	F2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NI IMBED: ` ´		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	11		STREET ADDRESS, CITY, STATE, ZIP CODE		09/29/2010	
				7300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pag	e 16	F 28	32			
F 282	· · · · · · · · · · · · · · · · ·	LIFIED PERSONS/PER	F 28			10/21/16	
SS=D	CARE PLAN	LIFIED FERSONS/FER	F 20	32		10/21/10	
33-0	CFR(s): 483.20(k)(3)	(ii)					
	- (-) ()(-)						
	The services provide	d or arranged by the facility					
	must be provided by						
		h resident's written plan of					
	care.						
	This RE∩UIREMEN	Γ is not met as evidenced					
	by:	i la fiat mat de evidenced					
	· ·	on, staff interview and clinical		Corrective Action			
		determined that facility staff		The CNA Responsible for prov	iding		
	failed to provide serv	ices in accordance with the		pudding thickened liquids to R			
	written plan of care for	or one of 35 residents in the		#16 was immediately counsele	d and		
	survey sample, Resid	dent # 16.		re-educated regarding providi			
				correct consistency of liquids b	ased on		
	The facility staff faile			physicians orders.			
		ing his breakfast as ordered					
	by the physician and			2.Other Potential Residents			
	comprenensive care	plan for Resident # 16.		A review of all residents with p	-		
	The findings include:			orders for thickened liquids wa conducted on 9/28/16 for the li			
	The findings include:			meal and no other residents w			
	Resident # 16 was a	dmitted to the facility on		affected.	CIC		
		es that included but were not		directed.			
	_	pathy (1), dysphagia (2),		3.System Changes			
		ertension (4), kidney failure,		Nursing staff were re-educated	d regarding		
		(5) and heart disease.		providing the correct consister			
		,		based on physicians orders.	, ,		
	Resident # 16's most	recent comprehensive MDS		An observation of all residents	with		
		n admission assessment,		physicians orders for thickened	lliw sbiupil t		
		reference date (ARD) of		be conducted weekly x 3 mont			
		esident as scoring a two on		validate that the resident is red			
		mental status (BIMS) of a		correct consistency of thickens	•		
		eing impaired of cognition		Any areas of non-compliance			
		king. Resident # 16 was		immediately corrected and sta	íf		
	coded as requiring e	xtensive assistance of one		responsible will be counseled.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			l	C (20/2046	
NAME OF P	ROVIDER OR SUPPLIER	400221	1	STR	REET ADDRESS, CITY, STATE, ZIP CODE	09/	29/2016	
					0 FOREST AVE			
WESTPORT REHABILITATION AND NURSING CENTER				CHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 282	staff member for active An observation of Re on 9/28/16 at 8:50 a.r room, seated in his we neat and clean. The positioned in front of breakfast meal tray we front of him. Resident independently. CNA # 6 then entered Rescup of juice and a cup CNA # 6 placed the computed with the properties of Residents #16's coffer a honey or nectar thic of Resident # 16's roow with sign that docume LIQUIDS. Resident is The "Physician's Tele for resident # 16 documented with pudding through 9/30/2016 for "Diet: Pureed with put The facility "Diet Orde Special Diets" documented, "(Name The care plan for Resident of 9/12/2016 do Nutritional Status as a gain related to mech	sident # 16 was conducted m. Resident # 16 was in his heelchair and appeared over the bed table was Resident # 16 and his as on top of the table in t # 16 was observed eating (certified nursing assistant) ident # 16's room carrying a of coffee for Resident # 16. offee and juice on Resident and left the room. Resident if his juice. Observation of we and juice appeared to be ex consistency. Observation of me revealed a bulletin board ented, "NO HONEY is on PUDDING thick." In phone Order dated 8/5/16 in the phone of the dated 9/01/2016 in Resident # 16 documented, dding thick liquids." In Tally Report - Selected ented, "Special Diet: Thick der "Resident # 16)." Is ident # 16 with a revision ocumented, "Focus: evidenced by actual weight	F 2		4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review and recommendations.	to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				29/2016
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 7300 FOREST AVE RICHMOND, VA 23226	DE	1 00	-0.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 282	Date initiated 7/27/20 documented, "At risk related to UIT (urinar ESRD (end stage rer hemodialysis (6)." U documented, "Thicke Date initiated 08/08/20 On 9/28/16 at 9:00 at conducted with CNA liquids she brought to breakfast CNA # 6 st weren't thickened. It them." When asked wand juice were thicked CNA # 6 stated, "He conducted with RN (rasked what the consiliquids should be, RN pudding thick." After coffee and juice, RN to pudding consistent on 9/28/16 at 9:10 at conducted with LPN 3, unit manager. LPN process for ensuring correct liquid consiste "There is a list of resist that lists the consiste CNA checks the list at and it is reviewed with during report." After Order Tally Report - S# 3 was asked to defi	ned liquids as ordered. 116." Under "Focus" it for alteration in hydration y tract infection) HX (history) nal disease) with nder "Interventions/Tasks" it ned liquids as ordered. 1016." m. an interview was # 6. When asked what o Resident # 16 during his ated, "His coffee and juice took them and thickened what consistency the coffee ned to for Resident # 16, gets nectar thick liquids." m. an interview was egistered nurse) # 4. When stency of Resident # 16's I # 4 stated, "Should be looking at Resident # 16's # 4 stated, "It's not thickened cy."	F2	282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 09/29/2016	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	(administrative staff administrator, ASM for clinical services administrator, were No further informati References: (1) A term for any dalters brain function was obtained from http://www.ninds.nil y/encephalopathy.h (2) A swallowing disobtained from the whttps://www.nlm.nih sorders.html. (3) The term "seizu interchangeably with physical finding occur after an episoactivity in the brain. obtained from the work.	coximately 5:30 p.m. ASM immember) # 1 the # 4, assistant administrator and ASM # 4, assistant made aware of the findings. con was provided prior to exit. iffuse disease of the brain that a constructure. This information the website: n.gov/disorders/encephalopath ttm. corder. This information was rebsite: n.gov/medlineplus/swallowingdi re" is often used h "convulsion." A seizure is so or changes in behavior that ode of abnormal electrical This information was	F 2	,			
	obtained from the w	sure. This information was rebsite: .gov/medlineplus/highbloodpr					
		nent disorder. This ained from the website: .gov/medlineplus/parkinsonsdi					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C / 29/2016
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 282	>. It removes waste kidneys can no longe (and other types of di of the kidneys when the information was obtain https://medlineplus.go 00707.htm. NO CATHETER, PREBLADDER CFR(s): 483.25(d) Based on the resident assessment, the facility resident who enters the indwelling catheter is resident's clinical concatheterization was now ho is incontinent of treatment and services.	d-stage kidney failure gov/ency/article/000500.htm from your blood when your r do their job. Hemodialysis alysis) does some of the job hey stop working well. This med from the website: bv/ency/patientinstructions/0	F 2			10/21/16
	by: Based on observation document review and was determined that maintain a urinary cat for one of 35 resident Resident #5. The facility staff failed	n, staff interview, facility I clinical record review, it the facility staff failed to theter in a sanitary manner is in the survey sample, I to keep Resident #5's and tubing off of the physical		Corrective Action The Physical Therapist Responsible not keeping Resident #5's urinary of bag and tubing off the floor was counseled regarding infection control practices and care and maintenance indwelling Foley catheters. 2.Other Potential Residents	catheter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1	C 29/2016	
NAME OF P	ROVIDER OR SUPPLIER	ı	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 315	Continued From pag	e 21	F3	315				
	therapy floor on 9/28	/16 at 11:10 a.m.			An observation of all residents with			
	The findings include:				indwelling Foley catheters was comple on 9/28/16 and no other residents were affected.			
	8/15/16 with diagnos limited to: urinary tra and pressure ulcers. The most recent MD day assessment, wit reference date) of 8/having an eight out of interview for mental was moderately important the resident was confrom staff for activitie eating which the residently after the catheter than the catheter tubing another staff member exercise bike. During kicked the urinary tut stepping on it. At 11: the urinary catheter if the exercise bike. Review of the physical documented, "16 (free	S (minimum data set), a 14 h an ARD (assessment 29/16 coded the resident as of 15 on the BIMS (brief status) indicating the resident aired to make daily decisions. ded as requiring assistance as of daily living except for dent could perform he tray was set up. made on 9/28/16 at 11:10 in the physical therapy ident was sitting in a			3.System Changes Therapy staff were re-educated regard infection control practices and care and maintenance of indwelling Foley catheters. An observation of all residents with indwelling Foley catheters will be conducted weekly x 3 months to valida that catheters are not touching the floo Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the observations will be forwarded to the QAPI Committee for further review and recommendations.	d te		

A. BUILDING	(X3) DATE SURVEY COMPLETED		
495227 B. WING	C 09/29/2016		
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 03/23/2010		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 315 Continued From page 22 balloon). Foley Cath (catheter) (secondary) multiple open wounds. Routine Foley care QD (everyday) + PRN (as needed)" Review of the treatment administration record documented, "Insert 16FR (french) 5 cc dt (due to) excoriation to scrotum and multiple open wounds. Routine Foley cath care daily) + prn." It was documented that the catheter was in place and foley catheter care was provided daily. Review of the resident's care plan initiated on 9/26//16 documented, "Focus. Uninary incontinence related to DECREASED MOBILITY. DEBILITY. MULTIPLE HEALTH ISSUES. FOLEY CATHETER. Interventions. FOLEY CATHETER CARE AS ORDERED." An interview was conducted on 9/29/16 at 9:20 a.m. with CNA (certified nursing assistant) #9. When asked if it was acceptable to place the urinary catheter bag and tubing on the floor, CNA #9 stated, "No it's not." When asked why, CNA #9 stated, "Infection and germs." When asked how the urinary catheter bag was to be managed, CNA #9 stated, "We attach it to the bed or the wheelchair." An interview was conducted on 9/29/16 at 9:21 a.m. with RN (registered nurse) #4. When asked if it was acceptable to place the urinary catheter bag and tubing on the floor, RN #4 stated, "No ma'am." When asked why this was not acceptable, RN #4 stated, "Infection control and safety. We don't want them to trip over anything or get it pulled out either." On 9/29/16 at 10:15 a.m., ASM (administrative			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		C 09/29/2016	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 00/20/2010	
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F 325 SS=D	administration were An interview was co a.m. with OSM #9, to asked how a urinary OSM #9 stated, "I a (catheter). The cath discrete and cared for catheter should not stated, "Leakage, co Review of the facility Care, Urinary" docu Maintain clean tech manipulating the ca b. Be sure the cath are kept off the floor No further information MAINTAIN NUTRIT UNAVOIDABLE CFR(s): 483.25(i) Based on a resident assessment, the fact resident - (1) Maintains accep status, such as bod unless the resident's demonstrates that the	ASM #5, the assistant made aware of the findings. Inducted on 9/29/16 at 11:45 he physical therapist. When a catheter was managed, dready heard about the cath should have been more for." When asked why the be left on the floor, OSM #9 contamination and discretion." In y's policy titled, "Catheter mented, "Infection Control. 2. Inique when handling or theter, tubing or drainage bag. The ter tubing and drainage bag. The trubing are trubing and drainage bag. The trubing are tr	F 32		10/21/16	
	This REQUIREMEN	IT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1	C 29/2016
NAME OF P	ROVIDER OR SUPPLIER	L	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2010
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WESTPOR	RT REHABILITATION AN	D NURSING CENTER			RICHMOND, VA 23226		
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F 325	Continued From page	e 24	F3	325			
	by:				4. O a mana atina a A atina a		
		n, staff interview and clinical			1. Corrective Action		
		determined that the facility			The CNA Responsible for providing		
	staff failed to provide	ne of 35 residents in the			pudding thickened liquids to Residents #16 was immediately counseled and		
	survey sample, Resid				re-educated regarding providing the		
	Survey Sample, Nesic	dent # 10.			correct consistency of liquids based on	1	
	Facility staff failed to	provide Resident # 16 with			physicians orders.		
		uids during his breakfast.			priyererane er derer		
		C			2.Other Potential Residents		
	The findings include:				A review of all residents with physician	s	
					orders for thickened liquids was		
		dmitted to the facility on			conducted on 9/28/16 for the lunch time	е	
		es that included but were not			meal and no other residents were		
		pathy (1), dysphagia (2),			affected.		
		ertension (4), kidney failure,					
	Parkinson's disease ((5) and heart disease.			3.System Changes		
	Desident # 16's most	recent comprehensive MDC			Nursing staff were re-educated regardi		
		recent comprehensive MDS n admission assessment,			providing the correct consistency of liquid based on physicians orders.	uius	
	1 .	reference date (ARD) of			An observation of all residents with		
		sident as scoring a two on			physicians orders for thickened liquids	will	
		mental status (BIMS) of a			be conducted weekly x 3 months to		
		eing impaired of cognition			validate that the resident is receiving th	ne	
		king. Resident # 16 was			correct consistency of thickened liquids	S .	
	coded as requiring ex	tensive assistance of one			Any areas of non-compliance will be		
	staff member for activ	vities of daily living.			immediately corrected and staff		
					responsible will be counseled.		
		sident # 16 was conducted					
		m. Resident # 16 was in his			4. Monitoring		
		heelchair and appeared			Results of the audits will be forwarded	to	
		over the bed table was Resident # 16 and his			the QAPI Committee for further review and recommendations.		
	•	resident # 16 and his as on top of the table in			and recommendations.		
		it # 16 was observed eating					
		(certified nursing assistant)					
		ident # 16's room carrying a					
		o of coffee for Resident # 16.					
		offee and juice on Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 09/29/2016	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	03/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 325	# 16 then took a sip Residents #16's cof a honey or nectar the of Resident # 16's rewith sign that docur LIQUIDS. Resident The (Name of Dysp swallow study report "Potential additiona from dysphagia if the identified and/or tree complications secon Potential hospitalizate to identified dysphate overall cognitive and dysphagia, Increase choking on food, liq "Recommended Die Pudding thick liquid The "Physician's Tefor resident # 16 do pureed with pudding The POS (physician through 9/30/2016 for "Diet: Pureed with pudding thick liquids - Spoon." Undocumented, "(Name The care plan for Redated of 9/12/2016 for Redated	y and left the room. Resident of his juice. Observation of fee and juice appeared to be nick consistency. Observation oom revealed a bulletin board mented, "NO HONEY is on PUDDING thick." hagia Testing Company) to dated 8/5/16 documented, is patient's condition is not ated: Increased respiratory indary to identified dysphagia, ation complications secondary gia, Increased decline in did physical function related to ed risk for aspiration and uid, and medications." Under et it documented, "Puree. s." lephone Order" dated 8/5/16 cumented, "Diet change to gi thick liquids." In order sheet) dated 9/01/2016 for Resident # 16 documented, uidding thick liquids." der Tally Report - Selected mented, "Special Diet: Thick Inder "Resident # 16)." esident # 16 with a revision documented, "Focus:	F3	25			
	documented, "(Nam The care plan for Rodated of 9/12/2016 Nutritional Status as	ne of Resident # 16)." esident # 16 with a revision					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 09/29/2016		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		03/23/2010		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 325	therapeutic diet" documented, "Thick Date initiated 7/27/2 documented, "At ris related to UIT (urina ESRD (end stage re hemodialysis (6)." U documented, "Thick Date initiated 08/08/ On 9/28/16 at 9:00 a conducted with CNA liquids she brought breakfast CNA # 6 s weren't thickened. I them." When asked and juice were thick 6 stated, "He gets n On 9/28/16 at 9:05 a conducted with RN asked what the cons liquids should be RN pudding thick." After coffee and juice RN to pudding consisted On 9/28/16 at 9:10 a conducted with LPN 3, unit manager. LF process for ensuring correct liquid consis is a list of residents the consistency for checks the list at the is reviewed with the report." After review Tally Report - Select	Under "Interventions/Tasks" it ened liquids as ordered. 2016." Under "Focus" it k for alteration in hydration ary tract infection) HX (history) enal disease) with Under "Interventions/Tasks" it ened liquids as ordered. 2016." a.m. an interview was A # 6. When asked what to Resident # 16 during his stated, "His coffee and juice took them and thickened at what consistency the coffee ened for Resident # 16 CNA # ectar thick liquids." a.m. an interview was (registered nurse) # 4. When sistency of Resident # 16's N # 4 stated, "Should be or looking at Resident # 16's # 4 stated, "It's not thickened	F3	25				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
		495227	B. WING _			09/29/2016
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	'	30.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	for pudding thick liqued on 9/28/16 at approduction (administrative staff administrator, ASM for clinical services administrator, were administrator, were substantially for clinical services administrator, were substantially for any displaying the state of the substantial services administrator and substantial services administrator and substantial services administrator and substantial services administrator, were substantial services administrator, and substantial services administrator, and substantial services administrator, were substantial services administrator, were substantial services administrator, and substantial service	stated that spoon was coded uids. ximately 5:30 p.m. ASM member) # 1 the # 4, assistant administrator and ASM # 4, assistant made aware of the findings. on was provided prior to exit. ffuse disease of the brain that or structure. This information he website: .gov/disorders/encephalopath m. order. This information was ebsite: gov/medlineplus/swallowingdi e" is often used in "convulsion." A seizure is a or changes in behavior that de of abnormal electrical This information was ebsite: gov/ency/article/003200.htm.	F3	25		
F 329	essure.html. DRUG REGIMEN IS		F 3	29		10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		00	C
	ROVIDER OR SUPPLIER	11		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		9/29/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329 SS=D	unnecessary drugs. drug when used in exit duplicate therapy); or without adequate moindications for its use adverse consequences should be reduced or combinations of the resident, the facility rewished when the drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventice.	regimen must be free from An unnecessary drug is any accessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any easons above. ensive assessment of a must ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic and dose reductions, and	F 3:	29		
	by: Based on staff intervand facility document that the facility staff fregimen free from urevidenced by failure	riew, clinical record review, review, it was determined ailed to ensure a drug nnecessary drugs as to monitor the use of an tion for 1 of 35 residents in resident #14.		1.Corrective Action The documentation for Residen been updated to include quantit qualitative documentation and n of the use of Seroquel. 2.Other Potential Residents An audit of the documentation for	ative and monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				C / 29/2016
NAME OF PI	ROVIDER OR SUPPLIER	**		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2010
WESTBOR	RT REHABILITATION AN	D NUDSING CENTED		73	300 FOREST AVE		
WESTPOR	RI REHABILITATION AND	D NORSING CENTER		R	CICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 29	F3	329			
F 329	Resident #14 was ad 7/12/16 on the medic survey, there was no qualitative monitoring medication. The findings include: Resident #14 was ad diagnoses of but not disease, dementia wibipolar disorder, anxieto thrive, osteoporosis pulmonary disease, a most recent MDS (Miadmission assessment Reference Date) of 7 coded as being impailife decisions, scoring the BIMS (Brief Intervexam. The resident resident ransfers, dressing, hassistance for eating; bowel and bladder. A review of the clinical resident was prescrib antipsychotic medical twice daily. This medical twice daily.	mitted to the facility on ation Seroquel. As of this evidence of quantitative and of the use of this mitted on 7/12/16 with the limited to Alzheimer's th behaviors, psychosis, ety, depression, adult failure s, chronic obstructive and left ulna fracture. The nimum Data Set) was an ent with an ARD (Assessment 1/19/16. The resident was red in ability to make daily an 8 out of a possible 15 on view for Mental Status) required total care for ygiene, and bathing; limited and was incontinent of all record revealed the ed Seroquel (an tion (1)) 25 mg (milligrams) lication was ordered at	F3	329	others residents receiving antipsychotic medications was completed and no oth residents were affected. 3. System Changes Unit Managers and licensed nurses hat been re-educated on monitoring and documentation for residents receiving antipsychotic medications. A 100% audit of all residents receiving antipsychotic medications will be completed weekly x 3 months to valida compliance with monitoring and documentation related to the use of the medication. Any areas of non-compliant will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review and recommendations	ve te e nce	
	admission assessment Reference Date) of 7, coded as being impail life decisions, scoring the BIMS (Brief Intervexam. The resident resident resident resident resident and bladder. A review of the clinical resident was prescrib antipsychotic medical twice daily. This mediated admission on 7/12/16. A review of the progref following: A physician's progress documented, "Alzh	nt with an ARD (Assessment /19/16. The resident was red in ability to make daily an 8 out of a possible 15 on view for Mental Status) required total care for ygiene, and bathing; limited and was incontinent of all record revealed the red Seroquel (an tion (1)) 25 mg (milligrams) lication was ordered at it.			medication. Any areas of non-compliar will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review	nce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 09/29/2016		
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	ODE	33.23.20.10		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 329	Continued From pag	e 30	F	329				
	"Resident continues Hollering she needs	7/14/16 which documented, to roll up and down halls. help. When asked what she sn't know just help"						
	documented, "Psych is clinically contrained patient, as if we belie imbalance, then we can and will lead to staking a diabetic off their meds. PT (p	are inviting a situation that suffering. This is akin to their insulin or a hypertensive patient) is at end of life care appropriate to leave them on						
		8/26/16 documented, sly rings call bell, frequently die today"						
	"Resident alert with	e dated 8/26/16 documented, confusion. Resident I don't want to die"						
	"Resident continuous help. Resident responding. I don't want to Guarded imagery an attempted, unsucces	8/28/16 documented, sly calls staff to room for onds to staff stating "I'm o die, please help me." d deep breathing exercises ssful. Medicated with prn (as antianxiety medication (2))."						
		ove, it was also documented and 9/6/16 that the resident						
	quantitative and qua	evidence provided of litative documentation and e of Seroquel in the 11 weeks						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 09/29/2016
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226	, CODE	00.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIA	
F 329	Continued From pag (77 days) the resided beginning of this sur On 9/28/16 at 11:10 LPN #17 (Licensed I manager) she stated behavior notes on rebut that she had not because she did not She stated she thous discontinued when such a review of the care for adverse effects remedication" initiate the intervention, "Everifiects of medication decrease/elimination intervention was initiated to the facility of the fa	e 31 Int was in the facility as of the vey. a.m., in an interview with Practical Nurse, the unit I that she does weekly sidents on an antipsychotic done any on this resident know she was on Seroquel. I ght the Seroquel had been he was admitted to the unit. I plan revealed one for "At risk elated to use of antipsychotic ed on 7/30/16 and included aluate effectiveness and side is for possible of psychotropic drugs." This ated on 7/30/16. Ty policy, "Medication on Management"				
	medication, the behavior reevaluated periodic effectiveness of the apotential for reducing dosef. Before in antipsychotic medicathe target behavior respecifically identified and qualitatively, in condition*persiste continued treatment.	avioral symptoms must be ally to determine the antipsychotic and the g or discontinuing the itiating or increasing an ation for enduring conditions, must be clearly and and monitored objectively order to ensure the behavioral				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		495227	B. WING			C 9/29/2016
	ROVIDER OR SUPPLIER RT REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 environmental stressors*not due to psychological stressors or anxiety" On 9/29/16 at 11:36 a.m., the Administrator and Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine (Seroquel) have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. (1) Information obtained from https://medlineplus.gov/druginfo/meds/a698019.h tml (2) Information obtained from https://medlineplus.gov/druginfo/meds/a684001.h tml INFECTION CONTROL, PREVENT SPREAD,		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 00/20/20 10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	environmental stress psychological stress of death during Quetiapine is not ap Administration (FDA) behavioral stress psychological stress of demental stress of demental stress of death during Quetiapine is not ap Administration (FDA) behavioral problems	a.m., the Administrator and were made aware of the information was provided by y. bwn that older adults with sorder that affects the ability clearly, communicate, and es and that may cause ad personality) who take ications for mental illness) (Seroquel) have an increased treatment. proved by the Food and Drug a.) for the treatment of	F 32	29		
F 441 SS=D	https://medlineplus.gtml (2) Information obtathttps://medlineplus.gtml INFECTION CONTELINENS CFR(s): 483.65 The facility must est Infection Control Prosafe, sanitary and coto help prevent the control provent the control prov	gov/druginfo/meds/a698019.h ained from gov/druginfo/meds/a684001.h ROL, PREVENT SPREAD, ablish and maintain an ogram designed to provide a omfortable environment and development and transmission	F 44	11		10/21/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		0.0	C 9/29/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		5/29/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From paç	ge 33	F 4	41			
	Program under whice (1) Investigates, cordinate facility; (2) Decides what proshould be applied to (3) Maintains a reconductions related to infection (b) Preventing Spread (1) When the Infection determines that a reprevent the spread (1) isolate the resident. (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (5) The facility must hands after each direct contact will trace (6) The facility must hands after each direct contact will trace (6) The facility must hands after each direct contact will trace (6) The facility must hands after each direct contact will trace (6) The facility must hand washing is independent of the facility must hand washing is must hand washing in must hand washing was	ablish an Infection Control th it - trols, and prevents infections ocedures, such as isolation, an individual resident; and rd of incidents and corrective fections. ad of Infection on Control Program sident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted					
	by: Based on observati document review an was determined tha provide care and se	T is not met as evidenced on, staff interview, facility d clinical record review, it the facility staff failed to rvices in a manner to prevent 5 residents in the survey		Corrective Action The Physical Therapist Respond to the Responding Resident #5's urical bag and tubing off the floor working counseled regarding infection.	nary catheter as		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			B 14//NO			1	C
		495227	B. WING_			09/	29/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTDOE	RT REHABILITATION AN	D NUBSING CENTER		7	300 FOREST AVE		
WESTFOR	AT REHABILITATION AND	D NORSING CENTER		R	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page	e 34	F4	441			
	sample, Resident #5	and Resident #12.			practices and care and maintenance of indwelling Foley catheters.	=	
	1. Facility staff failed	to keep Resident #5's					
		and tubing off of the physical			The wheelchair cushion for resident #	12	
	therapy floor on 9/28/				was replaced on 9/29/16		
	2. The facility staff fa	iled to provide Resident #12			2.Other Potential Residents		
	with a wheelchair cus	shion in good repair, allowing			An observation of all residents with		
	it to be cleaned to pre	event the transmission of			indwelling Foley catheters was comple	ted	
	infection.				on 9/28/16 and no other residents were)	
					affected.		
	The findings include:						
					Wheelchair cushions were checked for	-	
		admitted to the facility on			other residents that have them in place	:	
	_	es that included but were not			and no other residents were affected.		
	and pressure ulcers.	ct infection, alcohol abuse			3.System Changes		
	and pressure dicers.				Therapy staff were re-educated regard	ina	
	The most recent MDS	S (minimum data set), a 14			infection control practices and care and		
		an ARD (assessment			maintenance of indwelling Foley	•	
		29/16 coded the resident as			catheters.		
		f 15 on the BIMS (brief			An observation of all residents with		
		tatus) indicating the resident			indwelling Foley catheters will be		
		ired to make daily decisions.			conducted weekly x 3 months to valida	te	
		led as requiring assistance			that catheters are not touching the floo	r.	
		s of daily living except for					
	eating which the resid				Nursing Staff were re-educated to		
	independently after th	ne tray was set up.			observe for wheelchair cushions that n	eed	
	A h	0/00/40 1 44 40			to be repaired or replaced during their		
		nade on 9/28/16 at 11:10			daily interactions with residents.		
		n the physical therapy			Rounds of all units will be completed weekly x 3 months to validate that		
	department. The residual wheelchair next to an				residents have appropriate wheelchair		
		neter and tubing were lying			cushion's that are not in need of repair	or	
		out approximately two feet			replacement	OI	
		t. OSM (other staff member)			Topiacomonic	ſ	
		apist, had his feet straddling			Any areas of non-compliance will be	ſ	
		nd with the assistance of			immediately corrected and staff	ſ	
	_	slid the resident onto the			responsible will be counseled.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _				C / 29/2016	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226	1 09/	29/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 441	kicked the urinary tustepping on it. At 11: the urinary catheter in the exercise bike. Review of the physic documented, "16 (free (cubic centimeters, a balloon). Foley Cath multiple open wound (everyday) + PRN (at Review of the treatmedocumented, "Insert excoriation to scrotur Routine Foley cath of documented that the foley catheter care with Review of the reside 9/26//16 documented incontinence related DEBILITY. MULTIPL CATHETER. Intervee CARE AS ORDERE! An interview was con a.m. with CNA (certif When asked if it was urinary catheter bag #9 stated, "No it's no stated, "Infection and the urinary catheter in the continence of the certification and the urinary catheter in the continence of the certification and the urinary catheter in the certifica	g the transfer OSM #9 gently bing to the side to prevent 16 a.m. OSM #9 picked up oag and hung it of the side of sian's orders dated 9/1/16 ench, size of catheter) 5 cc amount of water in catheter (catheter) (secondary) Is. Routine Foley care QD is needed)" The administration record 16FR (french) 5 cc d/t due to m and multiple open wounds. For a daily + prn." It was catheter was in place and was provided daily. The care plan initiated on the care of th	F4	141	4. Monitoring Results of the observations will be forwarded to the QAPI Committee for further review and recommendations.			
	CNA #9 stated, "We wheelchair." An interview was cor							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 09/29/2016
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		3372372010
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	bag and tubing on the ma'am." When ask acceptable, RN #4 safety. We don't was or get it pulled out to the contamination and make a contamination a	to place the urinary catheter the floor, RN #4 stated, "No ed why this was not stated, "Infection control and ant them to trip over anything either. 5 a.m., ASM (administrative he assistant administrator for d ASM #5, the assistant e made aware of the findings. 5 anducted on 9/29/16 at 11:45 the physical therapist. When y catheter was managed, already heard about the cath. It we been more discrete and sked why the catheter should for, OSM #9 stated, "Leakage, discretion."	F 44	1		
	Care, Urinary" docu Maintain clean tech manipulating the ca b. Be sure the cath are kept off the floo No further informati	ty's policy titled, "Catheter umented, "Infection Control. 2. Inique when handling or atheter, tubing or drainage bag. eter tubing and drainage bag ir." ion was provided prior to exit. as admitted to the facility on noses including, but not limited ike, dementia, and diabetes.				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 09/29/2016
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		03/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 37	F 4	41		
	quarterly assessmedate 7/21/16, Residuely cognitively decisions. She was	MDS (minimum data set), a ent with assessment reference dent #12 was coded as being impaired for making daily secoded as requiring a motion in her room and around				
	a.m., Resident #12 wheelchair in the haboth occasions, the Resident #12's whe	p.m. and on 9/29/16 at 9:15 was observed sitting in her allway outside her room. On cover of the cushion in elchair was observed to be of exposed foam rubber.				
	Resident #12 dated updated 7/26/16 rev	prehensive care plan for 3/24/15 and most recently vealed, in part, the following: uting device on bed/chair."				
	assistant) #14 was interact with Reside her wheelchair. CN observed anything Resident #12. CNA When asked to look wheelchair and acc "Oh, I see it." She cushions for tears a stated she could se cushion's cover in sthis is acceptable font. When asked if #14 stated she was "We can't clean it." be followed if she odisrepair, she stated	a.m., CNA (certified nursing observed to pass by and ent #12 as the resident sat in IA #14 was asked if she out of the ordinary with A #14 stated she did not. If wore closely at the resident's essories, CNA #14 stated: stated she usually looks at end other abnormalities. She er a rip in the wheelchair everal places. When asked if or a resident, she stated it was the cushion was clean, CNA enot sure. CNA #14 stated: When asked the process to bserved a cushion in d: "I would call rehab ces). They will get a new one				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C / 29/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 09/	23/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
F 465 SS=D	nurse) # 15 was inter "not okay" for a resid cushion that is torn a She stated: "This is a would call the wound what kind of cushion has the same kind of On 9/29/16 at 11:25 a staff member) #1, the assistant administrate ASM #5, the assistan informed of these cor durable medical equi requested. A review of the facility "Disinfection/Steriliza related to providing re medical equipment in equipment to be clea No further information SAFE/FUNCTIONAL E ENVIRON CFR(s): 483.70(h) The facility must prov sanitary, and comfort residents, staff and the	am., LPN (licensed practical viewed. She stated it was ent to be seated on a and displaying exposed foam. In infection control issue. I nurse to help determine is needed. Not everyone cushion." a.m., ASM (administrative endoministrator, ASM #4, the for for clinical services, and at administrator, were incerns. Policies regarding preparent condition were y policy entitled attom provided no information esidents with durable and form that allowed for the need. In was provided prior to exit. In was provided prior to exit.	F 44			10/21/16
	by:	on and staff interview, it was		1.Corrective Action		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING_				C / 29/2016	
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	123/2010	
WESTDO	RT REHABILITATION AN	ID NUIDSING CENTED		73	300 FOREST AVE			
WESTPOR	RI REHABILITATION AN	ID NORSING CENTER		R	ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 465	Continued From pag	e 39	F 4	165				
	a safe environment i	facility staff failed to maintain n one of four facility shower			The Clorox Disinfectant spray was removed from the shower room by the			
	rooms, the shower ro Unit.	oom on the Monarch I (one)			unit manager.			
	observed in an unloc	Clorox disinfectant spray" was ked wall mounted cabinet in			2.Other Potential Residents All other shower rooms were checked of 9/29/16 and cabinets were locked.	on		
	The findings include:				3.System Changes Nursing Staff were re-educated on malesure that the cabinets in the shower rooms are locked when not in use.	king		
	shower room on the conducted with OSM maintenance superv shower room a 19 oudisinfectant spray" w	as observed in an unlocked			An observation of all shower rooms will conducted weekly x 3 months to valida that the cabinets are being kept locked Any areas of non compliance will be immediately corrected and staff responsible will be counseled.	te		
	disinfectant spray OS it." OSM # 8 was the	t. When asked who used the SM # 8 stated, "Nursing uses en asked to have the nursing the Monarch I Unit shower			4.Monitoring Results of observations will be forward to the QAPI Committee for further revie and recommendations.			
	conducted with LPN and OSM # 8 in the I After observing the "the unlocked wall maked what it was us disinfectant spray. L (certified nursing ass When asked how it stated, "It should be no one is in the show and LPN # 8 were as	a.m. an interview was (licensed practical nurse) # 8 Monarch I Unit shower room. Clorox disinfectant spray" in bunted cabinet, LPN # 8 was sed for and who uses the LPN # 8 stated, "The CNAs sistants) use it for odors." should be stored, LPN # 8 locked in the cabinet when ver room." When OSM # 8 sked to determine how much the can they both agreed that mately half full.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION SUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _				C 9/29/2016	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 465	Name: Clorox Common Disinfecting Spray." It it documented, "Cause May cause genetic ef Flammable aerosol." During the days of the residents observed enshower room unattenshower room u	eet" documented, "Product ercial Solutions® Clorox® Under "Hazard Identification" es serious eye irritation. fects. May cause cancer. e survey, there were no intering the Monarch I Unit ded. imately 10:45 a.m. ASM member) # 1 the ade aware of the findings. In was provided prior to exit. TE/ACCURATE/ACCESSIB Intain clinical records on each e with accepted professional rest that are complete; ed; readily accessible; and zed. Just contain sufficient the resident; a record of the ats; the plan of care and exercise results of any ing conducted by the State; It is not met as evidenced	F 4	14			10/21/16	
	Based on staff interv	iew, facility document review		Corrective Action				

PRINTED: 03/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		495227	B. WING _		09	9/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				7300 FOREST AVE			
WESTPO	RT REHABILITATION	AND NURSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 514	Continued From p	age 41	F 5	514			
	the facility staff fai accurate clinical re the survey sample 1. The facility staff	review, it was determined that led to maintain a complete and ecord for two of 35 residents in e, Resident's #15 and #6. failed to document the reason ng medication for Resident		Licensed Nurses were re-ed appropriate documentation of MARS (Medication Administration Records) for a medication the The physician and responsible Resident # 15 were notified of medication.	on back of ration at is refused ble party for of the refusal		
	2. The facility staff failed to include the hospice records on the facility chart for Resident #6. The Hospice provider for Resi contacted and instructed to play the Hospice notes on the chart						
	The findings included	de: as admitted to the facility on		2.Other Potential Residents An audit of the MARS (Median Administration Records) for a has been completed and no	all residents		
	6/16/16 with diagr limited to: high blo	noses that included but were not processure, dementia, ion, constipation, and a history		residents were affected. An audit was completed for a			
	of falls.	IDS (minimum data set)		residents to validate that the notes were present. No othe were affected.	hospice		
	assessment, a significant change assessment, with an assessment reference date of 8/25/16, coded the resident as being moderately impaired to make cognitive daily decisions. Resident #15 was coded as requiring extensive assistance of one staff member for all of her activities of daily living except, eating, in which she was independent after set up assistance was provided. The physician orders dated, 6/18/16, documented, "Senexon - S tab (used to treat constipation (1)) (tablet) 8.6 - 50 MG (milligrams); 1 tablet by mouth twice daily for Bowel Management."			3.System Changes Licensed Nurses were re-ed appropriate documentation of MARS (Medication Administr Records) for a medication th and the need for physician n regarding the refusal. A 100% audit of all MARS (Madministration Records) will be weekly x 3 months to validate with documentation and notification and notification and notification and documentation to be ochart.	on back of ration at is refused otification Medication be completed e compliance fication.		
	The July 2016 MA	R (medication administration		A 100% audit will be complete	ted weekly x 3		

Facility ID: VA0270

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 5012511			С		
		495227	B. WING _			09	/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				73	00 FOREST AVE			
WESTPO	RI REHABILITATION	AND NURSING CENTER		RI	CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 514	record) document MG; 1 tablet by m management." The following dates, a nurse for the 5:00 7/5/16 through 7/8 7/15/16 through 7/8 7/15/16 through 7/8 7/29/16. This was administration/docof the MAR did not administering the The August 2016 Tab 8.6 - 50 MG; bowel management the following date the nurse for the 8/2/16 through 8/8 This was eight of administration/docof the MAR did not administering the The nurse's notes "Made aware by 7 resident was consaware - VO (verballimediately)." The documentation on medication not be	ed, "Senexon S Tab 8.6 - 50 outh twice daily for bowel e MAR documented, on the circle around the initials of the p.m. scheduled dose: 7/2/16, 8/16, 7/10/15 through 7/13/16, /18/16 and 7/25/16 through 17 of the 31 opportunities for cumentation. The reverse side of document the reason for not medication on the above dates. MAR documented, "Senexon S 1 tablet by mouth twice daily for nt." The MAR documented, on s, a circle around the initials of 5:00 p.m. scheduled dose: 5/16 and 8/7/16 through 8/10/16. The possible 31 opportunities for cumentation. The reverse side of document the reason for not medication on the above dates. I dated, 7/19/16, documented, 7-3 (7:00 a.m. to 3:00 p.m.) shift stipated and (Name of doctor) all order) enema STAT here was no further the dates above regarding the	F	514	months of all residents on Hospice Services to validate presence of hospidocumentation. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded the QAPI Committee for further review and recommendations.			
	revised on 9/1/16, Elimination Alteral of exercise, const "Interventions" do medications per p	documented, "Focus: Bowel tion; Constipation related to lack ipation, impaired mobility." The cumented in part, "Administer						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 09/29/2016	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	•	33/23/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 514	asked what a circle at the MAR indicated, LI wasn't given. The nu back of the MAR why the doctor and the rest. An interview was commanager, on 9/28/16 what a circle around rindicated, LPN #3 sta administer the medication the back of the MAR notify the doctor and standard three thre	n 9/28/16 at 1:23 p.m. When round a nurse's initials on PN #7 stated, "It means it rese should document on the it wasn't given and notify sponsible party." ducted with LPN #3, the unit at 1:32 p.m. When asked nurse's initials on the MAR ted, "It means they didn't ation and they should write AR why they held it and the responsible party." dministering Medications" 18. If a drug is withheld, time other than the adividual administering the I and circle the MAR space and dose." mentals of Nursing-nd Wilkins 2007 page 165: tablet or capsule, be sure to ose given, date and time of gout the drug on the ecordany omission or for any reason. If a drug is omitted for any reason, the otified " member (ASM) #1, the 4, the assistant al services, ASM #4, the or, and ASM #6, the medical aware of the above concern	F	514			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 7300 FOREST AVE RICHMOND, VA 23226	•	09/29/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 514	No further information (1) https://dailymed.nlm.	e 44 n was provided prior to exit. nih.gov/dailymed/drugInfo.cf 820-4e07-962a-a50614594	F 5	514			
	8/15/14 with diagnose to: history of breast of arthritis. On the most data set), a significant assessment reference was coded as being it	admitted to the facility on es including, but not limited cancer, heart failure and t recent MDS (minimum at change assessment with e date 8/4/16, Resident #6 moderately impaired for its. She was coded as vices.					
	revealed an order da	al record for Resident #6 ted 7/25/16 stating that e evaluated and admitted to					
	at 3:28 p.m. failed to documentation relate services, including nuassessments, hospic support. At 3:28 p.m practical nurse) #3 wasurveyor the docume hospice provider regaservices. LPN #3 loo	y's clinical record on 9/28/16 reveal evidence of any other d to Resident #6's hospice ursing visits, social services e aide visits, and chaplain on 9/28/16, LPN (licensed as asked to show the ntation provided by the arding Resident #6's hospice oked through the chart and I think we usually have a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	433221		STR	REET ADDRESS, CITY, STATE, ZIP CODE	09/	29/2016
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			0 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	Continued From page	e 45	F t	514			
	I don't see anything.						
	director of nursing, st	nember) #3, the assistant opped the surveyor in the ed: "We just got these					
	charts yesterday." Sl chart labeled with the	ne showed the surveyor a name of Resident #6 and ice provider. The chart					
	contained records of	nurse, aide, chaplain and sits, as well as care plans.					
	print date and time of	e pages in the chart had a 9/27/16 at 1:43 p.m. (after					
	stated the hospice stated usually come in, visit	tered the facility). LPN #3 aff (especially the nurses) the resident, type their					
	directly on the chart.	s, and then put the notes ASM #3 stated: "I don't se notes or created these					
		ot have access to this spice company's website." erday was the first time I					
	have seen these char	ts. We used to have a tab. old notes off the charts and					
	staff member) #1, the						
	Program" revealed no	policy entitled "Hospice o information related to mentation being included on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DATE S COMPL	(X3) DATE SURVEY COMPLETED	
	495227	B. WING		00/3	9/2016	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		3/2016	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514 Continued From page the resident's clinical in No further information		F 5	14			